

KOH-00275793 IP5-00176272
Baby AARADHYA PANDEY
04-05-2015 11 Y 2 M 7 D (F)
Dr. P V L N MURTHY



ENTERED
SURGERY DETAILS

Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

81097
Patient Name: Baby. Aaradhya Pandey Date: 11/7/26.
Date of Birth: 4/5/2015 Age: 11Y
Gender: F Ward: O.T. UHID No.: KOH-00275793
Date of Surgery: 11/7/26 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Diagnostic nasal endoscopy
Canalization of suspected area little area

Time in: 6.25 pm. Time Out: 7.00 pm

	NAME	AMOUNT
1. Surgeon	P V L N MURTHY	
2. Anaesthetist	Dr. Surya	
3. Assistant Surgeon		
4. OT Technician	Sirishg	
5. Circulating Nurse	Ramadevi	
6. Assistant Nurse	Thejas	

Special Equipment: ☐ Laparoscopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others ☒

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9698493

Order by: Benjamin Terin

ESTIMATION SLIP

Date : 01/11/2026 UHID / IP No. : K04-0275797 SI No. 81097

Name of Patient: Deby Anandhya Pandey Age: 11/4/7m Gender: F

Father's / Husband's Name : Mr. J. K. Sharma Corporate / Occupation : Retired

Address : Hyd Phone : 888 677 7030 Email: _____

Procedure / Plan : Diagnosis of Nasal Endoscopy & Electrocauterization
of bleeding vessel & GA.

MODE OF PAYMENT: ☒ SELF ☒ TPA: Home X-ray - 2017 GIPSA: 1 OTHERS: 1

TARIFF INFORMATION:[illegible]

PARTICULARS			AMOUNT		
Surgeon's / Anesthetists's Fee / O.T. Charges			13,200 + 6000 + 10,000		
O.T. Consumables			Subject to approval by TPA / Insurance Company		
Instrument Charges			Not Covered by TPA / Insurance company		
Pharmacy, Consumables & Investigations			As per actual - Not Included in Estimation		
Equipment Charges	Monitor :		Oxygen :		Infusion pump / Syringe pump :
	Ventilator :	Conventional :	HFO-SLE 5000 :		HFO Sensormedix :
	Phototherapy :	Single Surface :	Double Surface :		Triple Surface :
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.			As per actual - Not Included in Estimation		
Package					
Others					
Initial Minimum Deposit					

REMARKS:

1. The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. **The estimated surgical charges may vary subject to surgeon's decisions / Complications/Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.**
3. In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
4. Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
5. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
6. For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
7. During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm
8. Difference, if any between the final bill amount and amount permitted/approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
9. Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

DECLARATION
I, Deeferend, have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital.

Signature of the Client

Signatory Relationship

Signature of the Financial Counselor

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176272

Admit Date : 11-Jul-2026

Admit Time : 04:25 PM

UHID : KOH-00275793

Patient Details :

Patient Name : Baby AARADHYA PANDEY

Age : 11 Y 2 M 7 D

Guardian : Mr JEETENDRA KUMAR PANDEY

DOB : 04-05-2015

Gender : Female

Religion :

Occupation :

Marital Status : Single

Address (H) : FLAT NO 721, BLOCK B, WESTERN PLAZA, OU
COLONY, SHAIKPET Golconda Hyderabad
Telangana INDIA 500008

Phone No : 8886773030/ 8886772020

E-mail : jitu_csebit@yahoo.co.in

Admission Details :

Bed Type : DAY CARE

Bed No : POST OP 409

Ward Name : 4F-OT COMPLEX

Room No : POST OP 409

Admission Type : First Visit

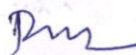
Contact Details :

Name : Mr JEETENDRA KUMAR PANDEY

Relationship : Father

Contact Address : FLAT NO 721, BLOCK B, WESTERN PLAZA,
OU COLONY, SHAIKPET Golconda Hyderabad
Telangana INDIA 500008

Phone No : 8886773030


Signature

Doctor Details :

Doctor Name : Dr. P V L N MURTHY

Specialisation : EAR NOSE AND THROAT

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : HDFC ERGO GENERAL INSURANCE
CO LTD

Nasal endoscopy

CONSUMABLES OF OT

Circulating staff : *11/6/16* Technician : _____ Date : _____ Time : _____

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used
ET tube	<i>1/1</i>	<i>1/1</i>	—	Major Pack	<i>1</i>	<i>1</i>		Inj Vit.K			
LMA	<i>1</i>	<i>03</i>		Sutures		<i>—</i>		Cord Clamp			
ECG leads : A / P / N	<i>5</i>	<i>03</i>						Suction Catheter			
HME filter : A / P / N	<i>1</i>	<i>01</i>						Feeding Tube			
Syringes : 10 cc	<i>10</i>	<i>02</i>						Vaccum Suction Set			
05 cc	<i>10</i>	<i>02</i>		Gloves	<i>(7) ps</i>	<i>2</i>		Surgical Gloves			
02 cc	<i>10</i>	<i>02</i>						Gauze Pack			
01 cc	<i>3</i>	<i>—</i>						Syringe 1ml / 2ml			
Cautery plate : A / P / N	<i>1</i>	<i>—</i>		Surgical blade				Surgical Blade # 20			
IV set	<i>1</i>	<i>—</i>		NG tube				Koochies (S)			
RL	<i>1</i>	<i>6</i>		Cautery pencil				<i>Chivindrops</i>		<i>2</i>	
NS : 10ml / 100ml / 500ml / 1000ml	<i>1</i>	<i>01</i>		Koochies				<i>1 cc + 5 cc</i>		<i>1/1</i>	
<i>minisplice</i>	<i>1</i>	<i>01</i>		Ointments							
<i>Vaccumset</i>	<i>1</i>	<i>01</i>		Suction Catheter							
Fentanyl	<i>1</i>	<i>01</i>		Cap, Mask	<i>45</i>	<i>5/5</i>					
Morphine				Gauze Pack	<i>(N) (R)</i>	<i>1/1</i>					
Ketamine				Mop Pack							
Propofol	<i>3</i>	<i>02</i>		Steristrip							
Rocuronium	<i>1</i>	<i>—</i>		Underpad		<i>1</i>					
Glycopyrolate	<i>1</i>	<i>—</i>		Draw sheet		<i>1</i>					
Myopyrolate	<i>1</i>	<i>—</i>		Abgel							
Ondansetron	<i>1</i>	<i>01</i>		Foleys catheter							
Pencan 25g/ Spinal Needle 22				Urobag				<i>N.A (24, 26)</i>	<i>1/1</i>	<i>—</i>	
Bupivacaine 0.25%	<i>1</i>			Chest Drainage Catheter				<i>O.A (2, 3)</i>	<i>1/1</i>	<i>—</i>	
Bupivacaine 0.25% (Heavy)				Romodrain bag				<i>Dexamethasone</i>	<i>1</i>	<i>—</i>	
Antibiotics <i>Aug (1.2gm)</i>	<i>1</i>	<i>01</i>		Bandage				<i>50cc + 100ml</i>	<i>2/1</i>	<i>—</i>	
<i>IV PCM</i>	<i>1</i>	<i>01</i>		Tegaderm							
Suppositories				Ioban							
Anamol : 80mg / 250mg / 170 mg				Double J Stent							
Supridol : 100mg				Vaccum Suction set		<i>1</i>					
Justin : 12.5 mg / 25mg / 100mg	<i>2</i>	<i>—</i>		Plastic Bed Sheet		<i>—</i>					
Tab. Misoprost : 200mg				Betadine Solution		<i>—</i>					
<i>3 way 10 + 100cm</i>	<i>1/1</i>	<i>01</i>		Microshield		<i>—</i>					
<i>Glove all + Gauze</i>	<i>4/4</i>	<i>0/4</i>		Cotton Balls		<i>—</i>					
<i>Janexa + Dexa</i>	<i>2/1</i>	<i>0/1</i>		Latex Gloves		<i>—</i>					
<i>1/1 cathula (1820)</i>	<i>1/1</i>	<i>—</i>		Ramdione Scrub		<i>—</i>					
<i>02 mask (A)</i>	<i>1</i>	<i>—</i>		Saral							

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____

Date of Admission: _____

Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

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Charge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	5:30 pm	ER	OT	
11/7/26	8 pm	OT	337	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Investigations

Signature

Blood Group

७५५

[Signature]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

[illegible]

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



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PEDIATRIC IN-PATIENT MEDICAL RECORD

KOH-00275793 IP5-00176272
Baby AARADHYA PANDEY
04-05-2016 11 Y 2 M 7 D (F)
Dr. P V L N MURTHY



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

compliance

Desired goals of the treatment : _____

stability

Planned Labs:

Blood grouping

NIB

sage1

11/7/26

5:30 pm

Planned Management

NPO

IV fluids

PRBC 1 unit

NIB

sage1

11/7/26

5:30 pm

Signature of the Doctor: *[Signature]*

Name of the Doctor: *Dr. P V L N MURTHY*

Date & Time: *11/7/26*

Signature of the Consultant: *[Signature]*

Name of the Consultant: *Dr. P V L N MURTHY*

Date & Time: *11/7/26 6 pm*

DR. P V L N MURTHY
Registration No: 47267

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 Baby AARADHYA PANDEY
 04-05-2015 11 Y 2 M 7 D (F)
 Dr. P V L N MURTHY



EFFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1+1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet	1			
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	1			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)	1			
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation	1			
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	1			
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)	1			
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale				
39	Bed side check list				
40	PICU bed formula Dilution feeds	10			
41	Gastro monitoring chart				
42	Rch ED doctors note	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
Total No. of Pages		36			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



OPERATION THEATER NOTES

Patient's Name : Baby Aaradhyaa Pandey Age : Gender : ☐ Male ☐ Female

UHID No.: KOH-00275793 Weight : 65.25kg Height :

Surgeon : <u>DR. Pr L N MURTHY</u>	Asst. Surgeon :
Anesthetist : <u>DR. Ravi</u>	OT Nurse: <u>Theyag, Romy</u> OT Technician: <u>Srisha</u>

Pre-Operative Diagnosis: Epistaxis for Eval

Surgical Procedure : Diagnostic nasal endoscopy

Indications for Surgery :

Date : <u>11/4/26</u>	Start Time : <u>6:35PM</u>	End Time : <u>6:55PM</u>
-----------------------	----------------------------	--------------------------

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: Diagnostic nasal endoscopy

- Nasal & NPX - (N)

no active bleeding

- cautirization of suspected littlep

area done

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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
 (Signature & Stamp)

Date: Time:

Note: Plan of care will be readjusted if necessary.

Date & Time	Progress Notes	Doctor's Order
11/2/26 10pm	<u>CBS Resident</u> No fresh issues doing well. St. 505 Ms / 10	<u>Sto</u> 1) Lt. same ASD 2) T. doing well Sto <u>Shambles</u> Wrote by Shambles



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: OT

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. P. V. L. N. Murthy

Date & Time: 11/7/26

Nurse Name & Signature: Sagan

Date & Time: 11/7/26 @ 5:30 pm

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 04-05-2015 11 Y 2 M 7 D (F)
 Dr. P V L N MURTHY

DRUG CHART

Date of Admission: 11/7/26 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : <u>T. DOLD 650mg</u>				Date Time
Dose <u>1kg PO</u>	Route <u>PO</u>	Frequency <u>6hrly</u>	Start Date <u>11/7</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions: <u>pain / TD 100%</u>				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

REGULAR PRESCRIPTIONS

Weight. 65.25 kg Ward.



DRUG .				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : T. TRAVEXA				Date Time 11/7
Dose 500mg PO	Route	Frequency BD	Start Date 11/7	10 AM NOT
Name & Signature of the Doctor Starting the Drugs:				gaur.
Additional Instructions:				lop prathi me clerk
Daily Doctor's Endorsement by a Sign				
DRUG : T. DACT				Date Time 11/7
Dose 4A	Route	Frequency TID	Start Date 11/7	6 AM
Name & Signature of the Doctor Starting the Drugs:				2p
Additional Instructions:				lop
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Patient Sticker

Weight. 65.25kg Ward.

VARIABLE DOSE		Date Time							
			Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date		Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.

VARIABLE DOSE		Date Time							
			Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date		Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
11/11/26	6:50pm	Dry: PARACETAMOL	100 mg	Po	✓	<i>[Signature]</i>

I.V. FLUIDS CHART

Weight. 56 kg Ward.

[illegible]

Children's Observation & Early Warning Scoring Chart



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]

104
103
102
101
100
99
98
97
96
95
94

9.9 of

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

[illegible]

1000/m 10/b/w

70
60
50
40
30
20
10

21blm 22blm

[illegible]

15/11/2023 15/11/2023

Initials

Score 1	: Continue normal observation by staff nurse	
Score 2	: Shift in charge nurse to be informed and continue hourly observations	
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.	
Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see	
Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.	

or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse		
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine					
			Mouth	I.V	N.G										
	08:00 am														
	09:00 am														
	10:00 am														
	11:00 am														
	12:00 pm														
	01:00 pm														
Total Intake :						Total Output :									
	02:00 pm														
	03:00 pm														
	04:00 pm														
	05:00 pm														
	06:00 pm														
	07:00 pm	H ₂ O	-	-	-	-	-	-	-	-	0				
Total Intake :						Total Output :									
	08:00 pm	Brew	-	-	-	-	-	-	-	-					
	09:00 pm														
	10:00 pm	Good													
	11:00 pm														
	12:00 am	H ₂ O													
	01:00 am														
Total Intake :						Total Output :									
	02:00 am														
	03:00 am	H ₂ O													
	04:00 am														
	05:00 am	H ₂ O													
	06:00 am														
	07:00 am	H ₂ O													
Total Intake :						Total Output :									
Total 24 hrs. Intake													Total 24 hrs. Output		



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
	Total Intake :						Total Output :						
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

KOH-00275793 IP5-00176272
 Baby AARADHYA PANDEY
 04-05-2015 11 Y 2 M 7 D (F)
 Dr. P V L N MURTHY



NURSING CARE RECORD

Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date:

Assessment:

Goals

- ☒ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications

- ☒ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....

- ☒ Maintain Fluid Balance
- ☐ Meet Elimination Needs

- ☒ Improve Activity Tolerance
- ☐ Ensure Safety

- ☒ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety

- ☒ Maintain Skin Integrity
- ☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the patient general condition. * Maintain I/O chart. * Monitoring the vital signs * ensure safety. * Administering the Medications as per orders	2pm	* Assessed the patient general condition * Maintain I/O Chart * Monitoring the vital signs. * Administering the medication	Nil
8pm		8pm		

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time: 11/7/16

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 11/7/20

Assessment: patient having mild pain

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☒ Prevent Infection
- ☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☒ Ensure Safety
- ☒ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient.	8:05pm	Assessed the patient.	Patient was stable.
10pm	General condition.	10:05pm	General condition	
12AM	Monitor the vitals.	12:05AM	Monitored the vitals	
2AM	Maintain I/O chart.	2:05AM	Maintained I/O chart.	
4AM	Provide comfortable.	4:05AM	Provided comfortable.	
	Position to patient.		Position to patient.	
7AM	To encourage orally.	7:05AM	Encouraged orally.	
	Intake.		Intake	
9AM	To Administer medication.	9:05AM	Administer medication.	

Re-Assessment: after providing comfortable position Patient was stable.

Special Notes: NA

Nurse Signature: S

Nurse Name: Shri's h.

Date & Time: 12/7/20 8AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: PVLN MURTHY Department: ER Date of Admission: 11/7/26

SITUATION	Diagnosis: <u>Endoscopy</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	<u>ER</u>	<u>OT</u>	<u>3rd floor</u>			
	Shift Time	<u>5:30 pm</u>	<u>2nd shift</u>	<u>3rd shift</u>			
	Medical Condition (Any special condition to be noted):	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98°F</u>	<u>98.8°F</u>	<u>98.1°F</u>		
		Res:	<u>24b/m</u>	<u>24b/m</u>	<u>24b/m</u>		
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>		
		Pulse:	<u>82b/m</u>	<u>82b/m</u>	<u>82b/m</u>		
		BP:	<u>118/55</u>	<u>118/60</u>	<u>110/70</u>		
	Fall Risk Score:	<u>9</u>	<u>9</u>	<u>9</u>			
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>			
	Recommendations	Safety Needs:	<u>Yes</u>	<u>yes</u>	<u>yes</u>		
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>			
Special Diet:		☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
Other Special Orders / Medications:		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>			
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>No</u>	<u>Nil</u>			
Handed Over By Name :		<u>Sagar</u>	<u>Srin</u>	<u>Shrisha</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>11/7/26</u>	<u>11/7/26</u>	<u>12/7/26</u>			
Time:		<u>5:30 pm</u>	<u>2nd shift</u>	<u>2nd shift</u>			
Taken Over By Name :		<u>Srin</u>	<u>Shrisha</u>	<u>[Signature]</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>11/7/26</u>	<u>12/7/26</u>	<u>12/7/26</u>			
Time:		<u>6:00 pm</u>	<u>2nd shift</u>	<u>2nd shift</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:						
	Temp:						
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7/20	9pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil	
11/7/20	6pm	0/10	abd	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	slowly
12/7/20	6am	0/10	abd	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	slowly
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

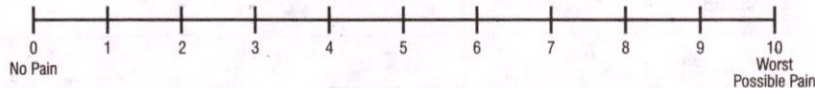
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

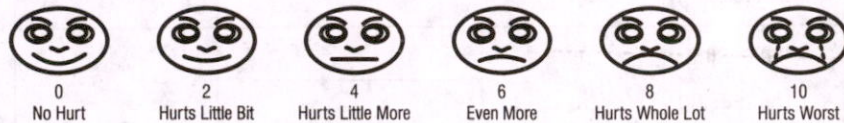
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



BRADEN 'Q' SCALE

					Date : 11/7	12/7		
					Time : 4 pm	8 AM		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation. OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
TOTAL SCORE					28	28		
Evaluator's Name					8	8		

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Hindi Patient / Learner Literacy: ☒ Read ☒ Write ☐ Speak Willingness to Learn: ☐ Yes ☒ No Healthcare Literacy: ☐ Yes ☒ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
11/7	4 pm	8.	procedures	M	4	0	1	1	-	SR
12/12/26	8 am	9	soft diet	m/f	1	0	1	1	-	SR

Part - III: CODES

Who was taught:		PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations		10. Financial Difficulties		13. Cultural/Religion Practice			
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home		11. Beliefs and Values		14. Others (Specify)			
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences		12. Impaired Vision/ or Hearing					
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs		7. Other, Specify					
2. -Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. I	strates Understanding		3. Needs Review					



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Endoscopy

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/7/26 4 pm	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☒ Per-Op ☐ Post Op	DIAGNOSTIC Nasal Endoscopy	Relief			☐ Nursing ☐ Others:
11/7/26 4 pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Endoscopy + caulk ation	H-stability	vitals monitoring		☒ Medical ☐ Others:
12/7/26 6 am	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Adenotonsillectomy	Soft diet	RDA E-T 700 kcal/d p- 29 gm/d		☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



THE HUMPTY DUMPTY SCALE

11/7 12/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2			
	13 years old and above	1					
Gender	Male	2	1	1			
	Female	1	1	1			
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			1	1			

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	✓			
Call device within reach	yes	✓			
Wheels Locked	yes	✓			
Room free of clutter	yes	✓			
Adequate Lighting	yes	✓			
Wheel Chair Support	NO	X			
Other Intervention(s) Specify	NO	X			
Nurse's Name :	Sagan	Shank			
Signature :	[Signature]	[Signature]			
Date :	11/7	12/7			
Time :	1 pm	8 AM			

KOH-00275793 Sticker
 Baby AARADHYA PANDEY IP5-00176272
 04-05-2015 11 Y 2 M 7 D (F)
 Dr. P V L N MURTHY

CHECKLIST FOR THROMBOPHLEBITIS

Rainbow[®]
 Children's
 Hospital
 It takes a lot to treat the little.

BirthRight
 BY RAINBOW HOSPITAL
 Your Right to a Safe Delivery

S. No.	OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		0	—	—						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		—	—	—						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		—	—	—						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		—	—	—						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		—	—	—						
Signature of the Nurse					Shreya	Shreya							

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : _____ Name : _____

Signature of Ward In Charge :

Signature : _____ Name : _____



INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☐ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1 Diagnostic Nod endoscopy
2

I acknowledge the following:

- I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
- The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)

- As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

a. Bleeding
b.

- I authorize Dr. PVLN Murthy and his / her team to perform the procedural sedation upon the patient / myself.

I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.

- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Teetendra

Name: Teetendra

Relationship with patient: Father

Date & Time: 11/2/26, 6:12pm

Witness:

Signature: Anjali

Name: Anjali

Date & Time: 11/2/26, 6:12pm

Doctor (who is taking consent):

Signature: PVLN Murthy Name: PVLN Murthy Date: 11/2/26 Time: 6:10pm

శస్త్రచికిత్స / ప్రాసీజర్కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
ఈ శస్త్రచికిత్స / ప్రాసీజర్కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్కు నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.
b.

4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Surgeon DR. PVLN MURTHY
Asst. Surgeon :
Anaesthetist : DR. Rami
Scrub Nurse : Tracy

Patient Name : Baby. aradhya pandey Age : 11 Y Gender : F
UHID No. : KOH-00275793 Surgery Name : Diagnostic lap- endoscopy
Date : 11/7/26 In-time : 6:25pm Out-time : 7:00pm

Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>6:15pm</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☒ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA	
Blood Units Reserved	☐ Yes ☒ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☐ Yes ☒ No ☐ NA	
Signature : <u>[Signature]</u>		
Name : <u>Dr. K Sri Surya</u>		

TIME OUT		Time: <u>6:35pm</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected, Steps, Operative Duration, Anticipated Blood Loss? <u>30min</u>		
	☐ Yes ☒ No ☐ NA	
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☒ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No		
Signature : <u>[Signature]</u>		
Name : <u>J. Ramakrishna</u>		

SIGN OUT		Time: <u>7:00pm</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded ☒ Yes ☐ No		
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☒ Yes ☐ No ☐ NA		
The Specimen is Labelled (including patient name) ☐ Yes ☒ No ☐ NA		
Whether there are any Equipment Problems to be addressed ☐ Yes ☒ No ☐ NA		
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No		
Signature : <u>[Signature]</u>		
Name : <u>PVLN Murthy</u>		



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 11/7

To Be Filled In By Assigned Nurse :

Department : O.T. Duration of Procedure : 30 min

Name of Surgeon : Dr. P V L N MURTHY Date of Admission : 11/7

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☒ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☒ No Name of the Antibiotic :	
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 31 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Date & Time of antibiotic administration : Date & Time procedure started : 11/7/26 @ 6:35 PM	

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

KOH-00275793 IP5-00176272
Baby AARADHYA PANDEY
04-05-2016 11 Y 2 M 7 D (F)
Dr. P V L N MURTHY

her Instructions:

Do Blood Grouping and
check Blood (COPRBS) availability
of that Blood Group on day of
(Sp.)



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Green

Time Received : 7:44

Time Discharged : 8 pm

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway
		Vomiting : ☐ Yes ☒ No NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☐ Yes ☒ No Chest Tube : ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids : Oral Feeds :

POST ANAESTHESIA SCORE (Modified Aldrete Score)		MINUTES			OUT	SCORING INTERPRETATION
		IN	30	60	90	
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	1	1	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	2	2	2	
BP $\pm$ 20 of Pre Anaesthetic level BP $\pm$ 20-50 of Pre Anaesthetic level BP $\pm$ 50 of Pre Anaesthetic level	= 2 = 1 = 0	CIRCULATION	1	1	2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	2	2	2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	1	1	2	
TOTAL			8	8	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
11/7/20	8:20	0/10	nil	<u>[Signature]</u>

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : D. Sri Sanyal

Anaesthesiologist Signature: [Signature]

Date & Time: 11/7/20 @ 8:20

PACU Nurse Name : Green

PACU Nurse Signature: [Signature]

Date & Time: 11/7/20 @ 8:20

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): 337

Date & Time: 11/7/20 @ 8:20

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal/Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right		Maternal		FHR	Comments
					BP	Pulse		

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: *Diagnosed Endometriosis + Embolisation of Bleeding Vessel & A*

Anaesthesiologist: *DR. K. SRIRAMYA* Surgeon: _____

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others: *DESATURATION, HYPOTENSION, laryngospasm*

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: *Teetendra Pandey*

Name: *Teetendra Pandey*

Relationship with patient: *Daughter*

Date & Time: *10.07.2026 10 PM*

Witness:

Signature: *Anjali dephi*

Name: *An*

Date & Time: *10/7/26*

Doctor (who is taking consent):

Signature: *A* Name: *DR. K. SRIRAMYA*

Date: *10/7/26* Time: *10:00 PM*

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాలు వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ లిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అల్టిర్ని ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్టిరియల్ లైన్, సపోజిటలీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:



EMERGENCY Triage FORM

Gender: ☐ Male ☒ Female
Triage Completion Time: 3:36 pm
☐ Not known any drug Allergies

Age: 11 yrs

Time of Arrival: 3:34 pm

Patient's Name: Aditya pandey
Date: 11/7/26
Allergies: ☐ Food ☐ Medications ☐ Other (Specify):
☐ Parents ☐ Others (Specify):
Arrival: ☐ Ambulance ☐ Stretcher
☐ Wheelchair

INITIAL PHYSIOLOGICAL STATUS

☐ Stable
☐ Unstable:
☐ Not - Life - Threatening
☐ Life - Threatening

LOGICAL CATEGORIZATION

Initial Vital Signs: Temp: 97.8
Chief Complaints: came for surgery
Circulation / Colour: ☒ Normal ☐ Abnormal ☐ Bleeding
Work of Breathing: ☒ Normal ☐ Decreased
Increased ☐ Gasping / Apnea

SpO₂: 92%
RR: 22/min
Diagnosis: Endoscopy + cautery of bleeding vessel & GA.

CTAS

☐ Immediate
☐ < 15 min
☐ 30 min
☐ 60 min
☒ 120 min

Triage Classification

- ☐ Level 1: Resuscitation
- ☐ Level 2: EMERGENT: Life or limb threatening
- ☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening
- ☐ Level 4: LESS URGENT: Significant illness but not life threatening
- ☐ Level 5: NON - URGENT: May receive care when convenient

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.
* CTAS - Canadian Triage and Acuity Scale

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No
If yes, State Location: _____
- Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

PART C. A positive disease triage screening is consent who meets one of the two follow

- ☐ Any path / Vesicles / Discharge from Eye and Co
- ☐ Any respiratory symptoms who answer "YES" on epidemiologic risk factors "PART B" above.

PART D. (for positive suspected screening)

- ☐ Pa (isolated in a negative press (appropriate) for pending evaluation)
- ☐ T (wearing surgical mask immediately, if appropriate)
- ☐ E (should perform hand hygiene. (appropriate).

Name of Triage Nurse: Bhavani
Date & Time: 11/7/26 @ 3:36 pm
Docu. No.: RCHBH / FRM / CLINICAL / 085

Inform consultant for positive criteria.

Nursing Notes (Including Labs / Medications / Other Care):

Nursing Notes

Time

Apm

→ Assess the pt & conscious.
→ seen Ramakrishna
→ vitals checked & Record.
→ pt shifted to OT

Time:

Time:

Samples collected by:

Samples sent by :

Medication given in ER:	Medication

Date / Time

Medication

Route

Dosage & Instructions

Doctor
Sign

Nurse
Sign

Condition of patient at time of shift - out :
BP: 118/52
SPO₂: 100%

HR:

RR:

Pain Score:

Pain Score:
Repeat RBS (if applicable):

☐ MLC☐ LAMA☐ BROUGHT DEAD

Details of Shift - out

Shift - out from ER to:
Time of Shift - out: ...
given to:

Handover given to:
(Nurse's Name)

Tick as applicable:

Tick as applicable: ☐ MLC
Procedures done with details (if any):

Name of the Nurse :

Date & Time :

Signature of the Nurse :

Name of the Nurse : Sajan
11/7/20

Name of the Nurse : Sagar
Date & Time : 11/7/26 @ 5:30 pm

PATIENT TRANSFER FORM

Patient Name & UHID No. KOH-00275793 IP5-00176272 Baby AARADHYA PANDEY 04-05-2016 11 Y 2 M 7 D (F) Dr. P V L N MURTHY		Date & Time of Admission 11/7/26 @ 4:25 pm	Date & Time of Transfer Order 11/7/26 @ 5:30 pm
		Transfer Ordered by Dr. Nandan	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? op file	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Proto Gown	①	
2.	Kooche	①	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. Sagar		Name of Person Ordered Transfer Dr. Nandan	
Patient & Clinical Records Received by : Savani			
Date & Time of Patient Received : 11/7/26 @ 5 PM			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- ☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No.		Date & Time of Admission	Date & Time of Transfer Order
KOH-00275793 IP5-00176272 Baby AARADHYA PANDEY (F) 04-05-2015 11 Y 2 M 7 D Dr. P V L N MURTHY 		11/7/26 @ 2pm	11/7/26 @ 7:30am
		Transfer Ordered by	Reason for Transfer
		Dr. PVLN Murthy	post op
From Unit	To Unit	Information to Attendant	
OT	3B2	Yes ☒ No ☐	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant	
Nil	28	Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	<i>Nil</i>		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring		Name of Person Ordered Transfer	
<i>Srai</i>		Dr. murthy	
Patient & Clinical Records Received by :		<i>Shish</i>	
Date & Time of Patient Received :		11/7/26 8:30pm	

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

KOH-00275793 IP5-00176272
Baby AARADHYA PANDEY
04-05-2015 11 Y 2 M 7 D (F)
Dr. P V L N MURTHY



Rainbow[®]
Children's
Hospital
It takes a lot to treat the little.

BirthRight[™]
BY RAINBOW HOSPITALS
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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 5.40pm Mode of Arrival: walk Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 6.6 kg Kg

..... nil Height: cm

Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>nil</u>	<u>nil</u>	<u>nil</u>

Family History:

No Significant

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No

If yes please list,

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:

Are the child's immunization up to date? ☒ Yes ☐ No

Current Medication: ☒ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 6.6 kg Length: Head Circumference (< 2 years):

Temp.: 98.7 HR: 121 RR: 21 BP: 115/78

Pain Score: 0 Specify Site: (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☐ No Score: 12 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 24) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:☒ No Abnormalities Detected☐ Underweight☐ Overweight☐ Special Feeding Method☐ Feeding Problem☐ Special diet☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening:☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives With *John*Siblings in household ☒ Yes ☐ No (if yes How Many?) *1*All Information Obtained From ☐ Patient ☐ Mother ☒ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to *John*Nurse Signature: *[Signature]*Nurse Name: *[Signature]*Date: *11/7/2016*Time: *6:00pm*

KOH-00275793 IP5-00176272
Baby AARADHYA PANDEY
04-05-2015 11 Y 2 M 7 D (F)
Dr. P V L N MURTHY

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: India

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: 10/7/26

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☒ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☒ Yes ☐ No

☐ Dressing ☒ Yes ☐ No

☐ Toileting ☒ Yes ☐ No

Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s:

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 10/7/26 2:00 PM

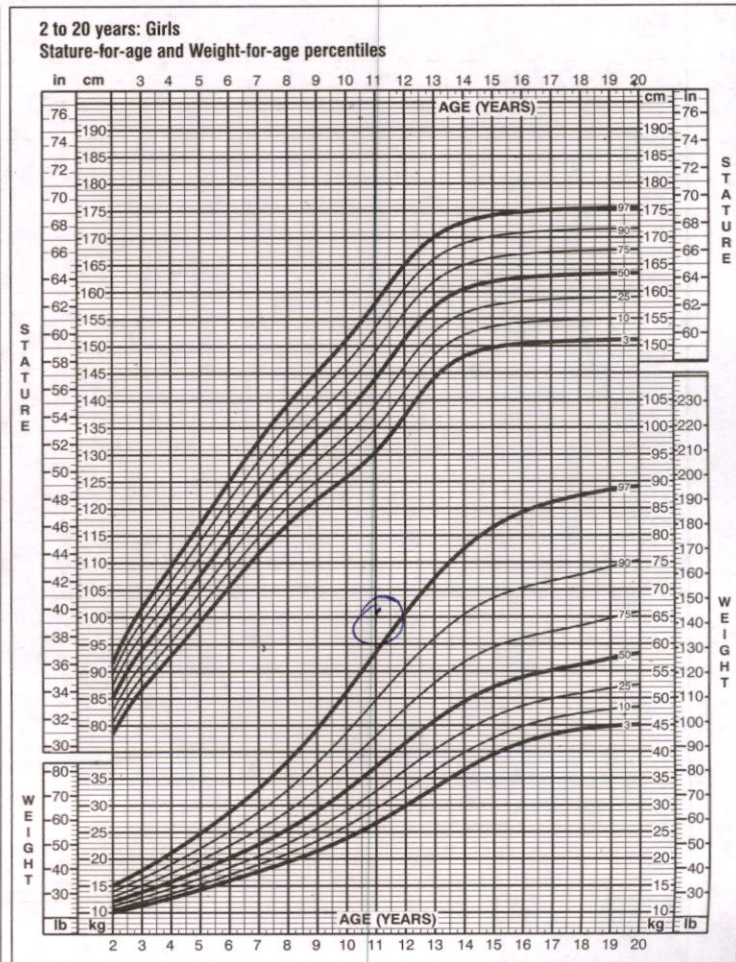
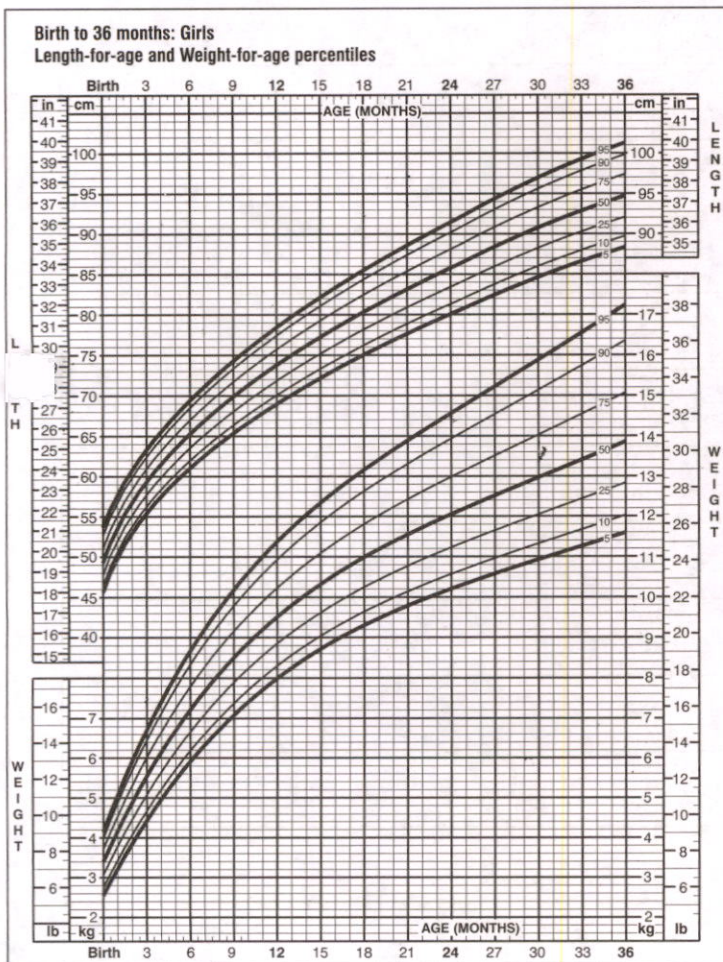
337

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 12/7/26 Time: 8:00am

Weight: 66 kg Centile: 79th
 Height: 135 cm Centile: 79th
 Inference: over weight child
 RDA: ———— Calories: 1700 kcal/d Protein: 29 gm/d
 Diet Recommendations: Soft diet
 Re-Assessment: Avoid Spicy & outside food
 Food Allergies: No Veg/Non-veg: veg
 Diagnosis: Adenotonsillectomy
 Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral
 Patient's Signature: Am

GROWTH CHART (GIRLS)



Dietician's Name: Lalima

Dietician's Signature: Lalima

Daily Notes:

[illegible]



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Aaradhya pandey Age : 11 yrs Gender: ☐ Male ☒ Female
Date : 11/7/26 Time of Arrival : 3:34 pm Triage Completion Time : 3:36 pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify):
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable : ☐ Not - Life - Threatening ☐ Life - Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

Initial Vital Signs: Temp: 97.8° PR: 92/6/m BP: 118/55 RR: 22/6/m SpO₂: 100%

Chief Complaints: came for surgery diagnostic study endoscopy + cautery of bleeding vessel & GA.

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☒ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian: [Signature]

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
If yes, State Location:
- Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Rhavana

Signature of Triage Nurse : [Signature]

Date & Time : 11/7/26 @ 3:36 pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 11/7/26 Time of arrival : 3:36 pm
Chief Complaints : Endoscopy RBS : /
Height : 150 cm Weight : 65.25 kg BMI : Head Circumference (<2 years)
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:
If yes, identify Nil
Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker
☐ Character Nil ☐ Location Nil ☐ Frequency Nil ☐ Duration Nil

RISK FOR FALL:

- ☒ If patient is < 6 years
tick below fall risk intervention directly
☐ If Patient is > 6 years
Assess the below parameters
History of Falling: within past 3 months ☐ Yes ☐ No
Ambulatory Aids:
• Wheelchair ☐ Yes ☐ No
• Uses furniture for support ☐ Yes ☐ No
Gait/Transferring:
• Bedrest / immobile ☐ Yes ☐ No
• Weak ☐ Yes ☐ No
• Impaired ☐ Yes ☐ No
Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☒ Escort while ambulating
☒ Assist Patient
☒ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

- ☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

- ☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

Siblings in household ☐ Yes ☐ No (if yes How Many?) Nil

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Nil Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 11/7/26

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
<u>4pm</u>	→ Assess the pt & conscious.
	→ Seen Ramakrishna
	→ vitals checked & Record.
	→ pt shifted to OT

Samples collected by: /

Time: /

Samples sent by: /

Time: /

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: BP: <u>118/52</u> CFT: <u>L25x</u> RR: <u>24 blm</u> SPO ₂ : <u>100%</u> GCS: <u>15/15</u> Temperature: <u>98°F</u> Pain Score: <u>0</u> Repeat RBS (if applicable): <u>Nil</u>	Shift - out from ER to: <u>OT</u> Time of Shift - out: <u>5:30 pm</u> Handover given to: <u>[Signature]</u> (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done.

Name of the Nurse: Sagar Signature of the Nurse: [Signature]

Date & Time: 11/7/20 @ 5:30 pm